Central Finance Office
c/o PDA Software Services
P.O. Box 29134
Shawnee Mission, KS 66201-9134

Missouri First Steps Early Intervention

Service Authorization/Billing
Discontinuation Notice

Client ID No.	Client's Name	Birthdate	Issue Date
9900-00001	JOHNNY PUBLIC	12/27/2001	08/12/2002
Telephone No.	**Head of Household**	**Authorization Service Dates**	
636-555-1234	JOHN PUBLIC	08/09/2002 to 02/12/2003	

NICE PROVIDER COMPANY
A. PROVIDER
123 CLEAN ROAD
SAINT LOUIS, MO 63103

Service Coordinator
Sally Provider
Inquiries regarding service call:
(866) 711-2573
Payment will be made to:
Nice Provider Company 00-0000000

Authorization Section: Subject to conditions on the IFSP, you are authorized to provide and bill for the services described below.

Procedure	Description	Frequency
6055	Service Coordination-Service Coordination (N/A)	15 minutes 1/Month

This authorization has been discontinued as of 10/29/2001. You are not authorized to provide any services related to this authorization after this date. Any claims submitted under this authorization for services provided after this date will be denied payment. If this action was to correct or update the original authorization, a replacement authorization may be in process. Please contact the service coordinator or the local First Steps System Point of Entry for additional information.

Billing Section: Please use this section of the form to bill for the services provided. Bills must be received within 60 days of service.

Authorization No.	Medicaid Provider ID	Medicaid PA	PCCM Referral	PCCM Code
A9900-00001-6				

Date of Service	Place Of Service Code	Procedure Code	Total Charges	Intensity In Minutes	Place of Service Codes (Use in Column 2)
					1=Home 2=Family Day Care 3=Nursery School/Child Care 4=Outpatient Service 5=EI Class/Program 6=Hospital (Inpatient) 7=Residential Facility 8=Other Setting

Payee Tax ID No.	Patient Account No.	Total Charges
00-0000003		

Submit bills to:

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Is this the final claim for this authorization? [ ] Yes [ ] No

Is this a resubmission of a claim? [ ] Yes [ ] No

I certify that the above billed services were provided in accordance with the child's Individualized Family Service Plan.

Provider's Signature _____ Date _____